6140 W. Atlantic Avenue * Delray Beach, FL 33484
Tel: (561) 498-4407 * (888) 357-DERM * Fax: (561) 498-4480
www.feinsteindermatology.com

NEW PATIENT INTAKE

Today's Date: ____________________ Reason for Visit: ____
How did you hear about Feinstein Dermatology:____

First Name:______________________________ Last Name:______________________________ Middle:________________
If minor, Parent/Guardian of Patient: _________________________________ Phone Number: ____________________________
Permanent (Local) Address: ____
City/State/Zip: ____
Secondary (Out of State) Address: ____
City/State/Zip: ____

Home Phone: __________________________ Cell: ____________________________ Work Phone: ______________________
Date of Birth:__________________________ Sex: ☐ M ☐ F
Email: ____ Marital Status: Single Married Divorced Widowed Separated
Employer:____ Occupation: ____
Race: __________________ Ethnicity: _______________________ Language Spoken: _________________________________

Preferred Contact Method: ☐ Home Phone or ☐ Cell Phone ☐ Text or ☐ Phone call

Preferred Time: ☐ Morning ☐ Afternoon ☐ Evening

Pharmacy:_______________________ City: __________________ Cross Street or Phone #: ____________________________
Primary Physician: ______________________________________ Phone Number: ____________________________________

Emergency Contact: _____________________________________ Phone Number: _______________________________________
Relationship to Patient: ____________________________________

Primary Insurance: ______________________________________ ID #:____
Secondary Insurance:______________________________________ ID #:____
Name of Policy Holder: ___________________________________Policy Holder Date of Birth:___________________________
Relationship to Policy Holder: ______________________________ Policy Holder Phone Number: _________________________

Are you interested in:
____ Cosmetics: Botox, Dermafillers
____ Laser: BBL Photofacial, Laser Hair Removal
____ Aesthetics: Microneedling, Rezenerate, Facial, Peels

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Patient's Name:____ DOB:_______________________ Date:__________________

Medications: ☐ Check if list attached, or list_________________________ **Allergies:**____________________________________

____ ______________________________________
____ ______________________________________
____

Past Medical History (Please check all that apply)

	Anxiety		Coronary Artery Disease		Hypercholesterolemia		Lymphoma
	Arthritis		Depression		Hyperthyroidism		Pacemaker
	Artrial fibrillation		Diabetes		Hypothyroidism		Prostate Cancer
	Breast Cancer		Renal Disease		Inflam. Bowel Disease		Radiation Treatment
	Colon Cancer		Hepatitis A B C		Leukemia		Seizures
	COPD		Hypertension		Lung Cancer		Stroke
			HIV/AIDS				
	Other:						

Past Surgical History (Please check all that apply)

	Appendix Removed		Breast Implants		Heart Transplant		Prostate Removed
	Bladder Removed		Gall Bladder Removed		Joint Replacement		Spleen Removed
	Mastectomy R L		Coronary Artery Bypass		Kidney Removed		Tubal ligation
	Lumpectomy R L		Valve Replacement		Kidney Transplant		
	Ovaries Removed Due to: ___Endometriosis ___ Cancer ___Cyst						
	Other:						

Dermatology History (Please check all that apply)

	Self	Family			
			Dysplastic (Atypical) Moles		Lifetime Sun Exposure: Mild Mod Heavy
Melanoma			Actinic Keratosis (Pre Cancer)		History of Blistering Sunburn: Yes No
Squamous Cell Carcinoma			Eczema/Psoriasis		History of tanning bed: Yes No
Basal Cell Carcinoma			Acne/Rosacea		Do you: Burn Tan Burn then Tan
Skin Cancer, Uncertain type				Sunscreen use: Always Occasionally Rarely	

Review of Systems (Please check all that apply)

Systemic		**Respiratory**		**Neurological**		**Dermatology**	
	Rheumatic Fever		Asthma		Dizziness		Skin Allergies
	Weight Loss		Shortness of Breath		Numbness		Bruises Easily
	Weight Gain		Hay Fever		Headaches		Hair Changes
	Herpes-Oral	**Gastrointestinal**-List complaints			Weakness		Nail Changes
	Herpes-Genital			**Urinary**-List complaints			Dry/Sensitive Skin
Eyes		**Musculoskeletal**					Rashes
	Cataracts		Artificial Joints	**Cardiovascular**			Bleeds Easily/Excessively
	Glaucoma		Muscle Pain		Heart Attack		Keloids (scars)
Ear, Nose, Mouth			Joint Pain		Swelling of Legs		Problems Healing
List complaints:		**Female**			Pacemaker or Defibrillator		
			Breast Lumps/lesions	**Misc:**			
Male			Pregnant				
	Testicular Lesions		Breastfeeding				

PATIENT SIGNATURE:____

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SOCIAL HISTORY QUESTIONNAIRE (For Quality Improvement - Required by CMS)

We thank you for your time!

Name:____ Date:_________________________

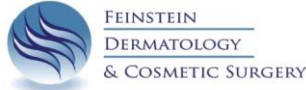
1. **Do you have an Advance Care Plan/Advance Directive (Living Will) in place with a named surrogate decision maker?**
   ☐ Yes (SDM) ☐ No (NSDM)

2. **Are you a:** ☐ Never Smoker ☐ Former Smoker ☐ Current Smoker

3. **If 'Former Smoker': How long has it been since you last smoked?**
   ☐ 1-3 Months ☐ <1 Month ☐ 3-6 Months ☐ 6-12 Months
   ☐ 1-5 Years ☐ 5-10 Years ☐ >10 Years

4. **If 'Current Smoker':**
   a. How often do you smoke cigarettes?
      ☐ Every day ☐ Some days, but not every day
   b. How many cigarettes a day do you smoke?
      ☐ 5 or less ☐ 6-10 ☐ 11-20 ☐ 21-30 ☐ 31 or more
   c. How soon after you wake up do you smoke your first cigarette?
      ☐ Within 5 minutes ☐ 6-30 minutes ☐ 31-60 min ☐ after 60 min
   d. Are you interested in quitting?
      ☐ Ready to quit ☐ Thinking about quitting ☐ Not ready to quit

5. **Have you had a drink containing alcohol in the past year?** ☐ Yes ☐ No
   a. If "Yes": How often did you have a drink containing alcohol in the past year?
      ☐ Never ☐ Monthly or less ☐ 2-4 month ☐ 2-3 week ☐ 4+ week
   b. If "Yes": How many drinks did you have on a typical day when you were drinking the past year?
      ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10 or more
   c. If "Yes": How often did you have 6 or more drinks on one occasion in the past year?
      ☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily/Almost Daily



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HIPAA, Notice of Privacy Practices Written Acknowledgement Form

I, ______________________________ (Print Name) have been given the opportunity to read a copy of Feinstein Dermatology & Cosmetic Surgery's Notice of Patient Privacy Practices.

____ ________________________________

Signature of Patient **Date**

1. May we leave appointment information on your answering machine or cell phone? ___Yes ____ No

   Please be advised that we are unable to leave lab results on an answering machine or cell phone.
2. Do you give our office permission to discuss your medical information with family members or other individuals (including spouse)? ____ Yes ____ No

   If yes, please provide their names & phone numbers below.

Name: _______________________________________ Phone:____________________ Relation:________________
Name: _______________________________________ Phone:____________________ Relation:________________
Name: _______________________________________ Phone:____________________ Relation:________________

AUTHORIZATIONS

For the release of medical records: I authorize the release of any medical information required by my insurance carrier(s) needed for any related claim. I authorize any holder and the health care financing administration or its intermediaries or carriers any information needed for this insurance claim or any related medical claim.

For the payment of benefits to the physician/provider: I understand that Feinstein Dermatology & Cosmetic Surgery has agreed to accept Medicare and/or Health Insurance for payment of my bills by my signature below. I acknowledge and understand that I am fully responsible at the time of services for any yearly deductible, co-pay and/or coinsurance balance due which is to be paid by me to Feinstein Dermatology & Cosmetic Surgery. I further understand that should payment be denied due to "PRE-EXISITING ILLNESS", NON-COVERED OR TERMINATION OF COVERAGE, I will be responsible for payment of such fees within 10 days of such notification. I understand that I will be billed for the remaining unpaid balance and I understand that I am financially responsible for any charges not covered. Payment is required at the time services are rendered

Self Pay Financial Policy: I understand, as a self-pay patient, that I am responsible to pay the bill at the time the services are rendered. These charges will include but not limited to consultation, laboratory fees, surgery fees and any other fees associated with my appointment.

Appointment Cancellation: Please be courteous and call Feinstein Dermatology and Cosmetic Surgery promptly if you are unable to attend an appointment. If it is necessary to cancel your appointment, we require that you give at least ***24 hours'*** notice. Less than 24 hours' notice doesn't allow us to offer an appointment to another patient in need. There will be a ***$50.00*** charge for a no show or cancel less than 24 hours. Unavoidable circumstances may warrant special consideration, but please note that the above charges will apply to most cancellations. .

The information requested on this form must be completed in its entirety and will remain confidential.

SIGNATURE: ________________________ **PRINT NAME:** ______________________ **DATE:** _________